BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

HYO N. TOPPING	)	
Claimant	)	
VS.	)	
	)	Docket No. 1,019,636
CONAGRA FOODS	)	
Respondent	)	
AND	)	
	)	
CONAGRA FOODS INC.	)	
Insurance Carrier	)	

ORDER

Claimant appeals the October 29, 2010, Award of Administrative Law Judge Rebecca A. Sanders (ALJ). Claimant was denied an award after the ALJ found that claimant had suffered no permanent impairment resulting from the three claimed accidents while working for respondent.

Claimant appeared by her attorney, Joseph Seiwert of Wichita, Kansas. Respondent and its insurance carrier appeared by their attorney, Joseph R. Ebbert of Kansas City, Missouri.

The Appeals Board (Board) has considered the record and adopts the stipulations contained in the Award of the ALJ. The Board heard oral argument on February 2, 2011.

ISSUE

What is the nature and extent of claimant's injuries and disability resulting from the three claimed accidents while claimant was employed with respondent? Respondent does not deny that claimant encountered some type of incident on the three dates of accident alleged: December 19, 2003; June 17, 2004 and August 2004. However, respondent denies that claimant suffered any permanent impairment resulting from those incidents. Claimant initially alleged that she was permanently and totally disabled as the result of several accidents suffered while working for respondent. However, that

argument was neither briefed nor argued to the Board. The Board finds that claimant has abandoned that issue.

FINDINGS OF FACT

Claimant began working for respondent in September 2003 as a line tender. Claimant's duties required that she clean intestines, carry buckets and cut tails. Claimant alleges three separate accidents while working for respondent. On December 19, 2003, claimant developed problems in her right shoulder and hand. Claimant's trainer noted that claimant had a bruise on her hand and it had started to swell. The accident was reported to claimant's lead person and claimant was told to see her supervisor. When claimant reported to the supervisor, she was told to see the company nurse. Claimant continued doing the same type of work for respondent. At some point, claimant was transferred to packaging.

Claimant was seen by Dr. Jenkins on January 6, 2004, complaining of left hand pain. Claimant advised that she had struck her hand on a sink and on a bucket. X-rays of the hand were negative for fracture. Claimant was diagnosed with a contusion to the left hand and placed on Naprosyn. Claimant was given light-duty restrictions and told to keep her hand covered and wrapped. On January 14, 2004, claimant was re-evaluated by Dr. Jenkins, reporting only minimal pain to her left hand. She was diagnosed with a predominantly healed hand contusion. The Naprosyn was stopped, and claimant was placed on Motrin and given a protective glove for her left hand. Claimant was to follow up as needed. Claimant was examined at the Geary Community Hospital occupational health clinic on January 16, 2004. She reported two traumas at work resulting in swelling and tightness in her left hand. No tingling, numbness or paresthesia were present.

Claimant advised Dr. Jenkins on February 12, 2004, of a re-injury on February 2, 2004, while performing repetitive activities bilaterally. Claimant also complained of pain in the right shoulder from pulling on a drain with her right upper extremity. Claimant alleged severe bilateral upper extremity pain with pain down the full length of both upper extremities. Claimant was also having cervical spine pain, headaches and mid back pain. The pain was so severe that it interfered with her ability to drive a car or dress herself.

The February 12, 2004, report to Geary Community Hospital discussed severe bilateral upper extremity pain from the shoulders into the hands and fingers with swelling in the hands and fingers, neck pain and headaches. On examination, claimant had slight swelling in the hands bilaterally with pain to the touch "anywhere"[1] in the upper extremities. Claimant was restricted to 10 pounds lifting, pushing and pulling, and no repetitive use of the upper extremities.

[1] See Hendler Depo., Ex. 3 at 2 (Dr. Hendler's February 19, 2010, report).

By February 19, 2004, claimant had been taken off work for two weeks by her family doctor. She reported pain to even superficial touch anywhere in her upper back, shoulders and extremities. It had earlier been noted that some personality conflicts may be exacerbating the current situation. Light duty and physical therapy were recommended. On February 26, 2004, claimant reported pain along her neck, upper back and suprascapular spine. No swelling was noted but a positive Finkelstein's test was noted. Possible exaggerated responses were noted with tenderness to palpation "anywhere"[2] throughout the upper extremities.

On March 4, 2004, claimant reported significant improvement with the therapy. However, she continued to be hyper-responsive to light touch in the shoulder region. On March 18, 2004, claimant displayed improved symptoms with no specific tenderness to palpation. By April 1, 2004, claimant's pain symptoms had returned in the wrists and elbows. Work restrictions by her family doctor continued. Claimant was determined to be at maximum medical improvement on May 4, 2004, even though she was displaying exquisite tenderness upon palpation of the wrists. She was allowed to return to regular duty so long as she wore wrist splints. By June 22, 2004, claimant was exhibiting symptoms of severe neck, shoulder and left lateral rib cage pain. The clinical impression was of trauma to the head and neck, left shoulder and left arm and ribs. Thoracic spine x-rays indicated mild degenerative changes of the lower thoracic spine but were otherwise unremarkable. Left shoulder x-rays were normal.

On June 17, 2004, claimant was working in packaging when she suffered a fall, injuring her neck, head and thumb. There is some indication in the record that claimant may have briefly lost consciousness. Claimant also later complained of problems with her bilateral upper extremities, including her hands, arms and shoulders. Claimant received medical treatment including physical therapy. Claimant felt that the physical therapy made her condition worse. Claimant was soon returned to the line where she worked until her termination on August 4, 2004, due to attendance problems. Claimant testified that as she continued to work, her condition worsened through her last day with respondent.

On June 25, 2004, claimant reported tenderness "along the spine of the scapula"[3] and an inability to actively or passively lift the left arm to the waist. An MRI of the left shoulder from July 8, 2004, was read as normal.

On July 14, 2004, claimant indicated increased pain in the right shoulder because of overuse. An MRI of the right shoulder was normal. Physical therapy was again recommended but the record indicates that claimant may have not been attending physical

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[2] Ibid., Ex. 3 at 2.

[3] Ibid., Ex. 3 at 2.

therapy. On July 28, 2004, claimant presented with additional improvement but continued guarding against practically any movement and displayed an inability to use the left arm. At that time, claimant was off work per her family doctor for "mental reasons". When claimant was next seen on August 26, 2004, she showed no improvement even though having been off work.

Medical notes from the Central Kansas Mental Health Center from July 2004 indicate claimant reported significant distress due to harassment on the job, comments of a sexual nature, problems with appetite, sleep disturbance, diarrhea and uncontrollable crying. Claimant was noted to be depressed and was to start on trazodone.

Claimant was referred to Dr. Galate for treatment in the fall of 2004. Claimant again had complaints of pain in the left shoulder and into her hands. Claimant was again provided treatment for the cervical region and left shoulder, including physical therapy and medications for the pain.

Claimant was referred by her attorney to board certified physical medicine and rehabilitation specialist George G. Fluter, M.D., on October 13, 2005. At that time, claimant complained of pain in the left shoulder girdle, the low back and buttocks, the left lower extremity and the left elbow. Claimant walked with a cane but did not appear to limp. Her gait was described as stiff and slow. Dr. Fluter performed an examination and diagnosed claimant with back pain, left leg pain, left shoulder and arm pain, neck pain and headache. During the physical examination, claimant displayed an absent Tinel's sign bilaterally at the wrists and elbows. There was generalized tenderness to palpation in the muscles of the neck, upper shoulders, scapular stabilizers, thoracic paraspinal muscles, lumbar paraspinal muscles and buttocks bilaterally. Physical therapy was again recommended, and EMGs of the left upper and lower extremities were recommended as well. Claimant was told to participate in a home exercise program. Pain and antidepressant medication were recommended as well.

Claimant was referred by the ALJ to John P. Estivo, D.O., for an independent medical evaluation on March 17, 2006. X-rays of the right and left shoulders, right and left wrists, right and left hips and lumbar spine were taken and all read as normal. EMG studies of both upper extremities were performed on April 3, 2006, with no abnormalities seen. During the physical examination, claimant displayed a positive Tinel's bilaterally at her wrists and tenderness in her shoulders bilaterally throughout range of motion. Claimant was diagnosed with right shoulder pain, left shoulder rotator cuff strain, cervicalgia with radiculopathy, lumbar spine strain, bilateral hip strains and possible carpal tunnel syndrome bilaterally. An MRI of the cervical spine was recommended as well as an MRI of the right shoulder. Claimant was returned to work with no more than a total of 20 pounds lifting and was to limit her bending, twisting and stooping to no more than one-third of the full workday.

Claimant returned to Dr. Estivo on April 12, 2006, after undergoing an NCT/EMG of both upper extremities. The tests were read as being normal. An MRI of the cervical spine indicated a very mild bulging disk at C6-7 with no neural impingement. The MRI of the right shoulder indicated inflammation to the supraspinatus portion of the rotator cuff as well as some thinning of the rotator cuff with a possible partial tear and some slight impingement. Degenerative changes to the AC joint were also indicated.

During the April 12, 2006, examination, claimant displayed extreme sensitivity to the slightest touch of her lumbar spine, cervical spine and upper extremities. Claimant's reaction was described as overreacting. Claimant claimed pain in her shoulders bilaterally and was resistant to moving her shoulders during the examination. But the doctor noted that when claimant relaxed, she seemed to be able to move her shoulders fairly well. Dr. Estivo was unable to explain claimant's reactions to the evaluation. Claimant was diagnosed with cervical spine strain, right and left shoulder strains with a possible partial thickness tear to the left rotator cuff, lumbar spine strain and bilateral hip strains. Dr. Estivo recommended injections to claimant's left shoulder at the subacromial space which claimant declined until she spoke to her attorney. Dr. Estivo found primarily soft tissue strains without a recommendation for surgery. Claimant remained on the 20-pound restriction with the remaining restrictions also continuing. Claimant returned to Dr. Estivo on September 22, 2006. At that time, she refused to be examined by the doctor. Claimant apparently was quite upset that the doctor had stated that she could work within restrictions. Claimant then left the doctor's office intending to see another doctor.

On December 15, 2006, claimant was examined by Dr. Michael Schuster, who diagnosed chronic low back pain; lumbar spine internal derangement; lumbar degenerative disk disease; sacroiliac joint dysfunction; myofascial pain syndrome; cervical spondylosis; possible cervical radiculopathy; and depression.

Claimant was evaluated by Dr. Nidal Yunis on October 1, 2007, for a three-year history of recurrent chest discomfort. Claimant was diagnosed with atypical mid-cervical discomfort suggestive of musculoskeletal problems. Nuclear images indicated no significant abnormality. Claimant also discussed fainting spells and recurrent dizzy spells.

Claimant sought medical treatment with Dr. Ali Manguoglu on February 18, 2008. At that time, she was diagnosed with posttraumatic neck pain, back pain, alternating bilateral arm and leg pain, and numbness with underlying cervical and lumbar spondylosis at C5-6 and L5-S1. A cervical MRI showed disk protrusions at C4-5 and C5-6. A discogram was definitely abnormal at L5-S1. Claimant was a possible candidate for surgery at L5-S1 with a possible implant or fusion. An anterior lumbar interbody fusion was performed by Dr. Gery Hsu on May 22, 2008.

Clamant was diagnosed with adhesive capsulitis of the right shoulder and chronic neck pain with a possible herniated nucleus pulposus by Dr. Michael Montgomery on August 6, 2008. Claimant also had impingement syndrome at the right shoulder. Manipulation under anesthesia was considered.

Claimant's additional medical treatment history is extensive. It is set out in some detail in the September 10, 2009, report of Dr. Fluter. By that date, claimant had pain complaints affecting her neck/upper back, both shoulders, both arms, middle back, low back, both hips, both legs and both hands. Her pain levels were at 8 to 9 on a scale of zero to 10. Claimant experienced daily pain and was confined to bed almost daily. Her pain was made worse by lying down, sitting, standing, walking, bending, twisting, exercise, cold/ice and heat. During the examination, claimant appeared uncomfortable and became tearful at times. However, she was able to transfer and ambulate independently without the use of an assistive device. At this time, Tinel's sign was absent bilaterally at the wrists, but positive at the elbows bilaterally. There was diffuse tenderness throughout multiple examinations in many areas of the body. Claimant was diagnosed with status post lumbar spine surgery at L5-S1, status post right shoulder surgery, with pain in her bilateral legs, low back, middle back, upper back and neck, with cervicothoracic myofascial pain and with a history of migraine headaches. Dr. Fluter rated claimant at 20 percent to the whole body for the lumbosacral spine surgery, 5 percent to the whole body for the cervical myofascial pain, 20 percent to the right upper extremity at the level of the shoulder, and 15 percent to the left upper extremity at the level of the shoulder. The total of the ratings combined for a 39 percent whole body impairment. Dr. Fluter determined that there was a causal/contributory relationship between claimant's current condition and the reported injury of June 17, 2004.

Claimant was referred by respondent to board certified physical medicine and rehabilitation specialist Steven L. Hendler, M.D., on February 19, 2010. Dr. Hendler was provided with extensive medical records and a history of claimant's three injury incidents with respondent. Claimant reported ongoing thigh pain, bilateral knee pain, neck pain with numbness, stabbing, burning and pins and needles, bilateral leg pain to mid calf on the right, occasional severe pain in her feet and continuous pain down both arms which claimant described as continuous since the injury. Claimant had either headaches or shoulder pain since the accident. After a physical examination, Dr. Hendler diagnosed claimant with a contusion of the left hand, resolved; a left shoulder strain which had resolved; a repetitive cervical strain that had resolved; degenerative joint and disk disease in the lumbar spine, post fusion; fibromyalgia; depression; and pain associated with both general medical condition and psychological factors. Dr. Hendler found no permanent partial impairment from the left hand injury of December 19, 2003, and no permanent partial impairment from the February 2, 2004, incident. Due to the improvement with the right shoulder post accident, he determined that claimant's current symptoms in the right shoulder were not related to the February 2, 2004, event. There was no permanent injury

to the left shoulder, and claimant's ongoing back problems were not related to the June 17, 2004, work event because contemporaneous medical records did not indicate any problems with the low back.[4] If claimant had suffered an injury severe enough to require low back surgery, it would have taken less than nine months for the symptoms to appear. Any conditions resulting from the described accidents had resolved, and claimant had a zero percent functional impairment from those incidents.

Claimant was referred by the ALJ to physical medicine and rehabilitation specialist Terrence Pratt, M.D., on June 21, 2010. The history provided by claimant included the three incidents above described. During the examination, claimant displayed four of five Waddell's assessment signs, indicating symptom magnification. Three or greater is considered significant.[5] Claimant reported cervical involvement from the December 2003 incident. However, Dr. Pratt was unable to find medical records that would corroborate cervical issues in December 2003. There were documents in the records of cervical involvement after the June 17, 2004, incident. Dr. Pratt noted claimant's history of depression. He identified functional overlay during the examination with responses which are not considered as consistent with any specific physical abnormality. Claimant displayed giveaway weakness, inconsistent shoulder range of motion limitations and the above noted Waddell's assessments.

Claimant was assessed a 5 percent whole person functional impairment to the cervical spine with 2 percent of that preexisting. Claimant was rated at 10 percent impairment to the whole person on a functional basis to the lumbar spine, 12 percent impairment to the right upper extremity at the level of the shoulder and 6 percent impairment to the left upper extremity at the level of the shoulder of which 3 percent would relate to preexisting involvement. All combined, claimant was assessed a 21 percent permanent partial whole person functional impairment. Claimant was restricted to no repetitive overhead activities with her bilateral upper extremities, no frequent bending or twisting, maximum lifting of 10 to 15 pounds and maximum pushing and pulling of 30 pounds. Dr. Pratt was unable to say within a reasonable degree of medical probability which restrictions would be assigned to what particular injury or accident. The restrictions were assigned based upon claimant's physical condition as he observed.[6] After reviewing the task list of vocational expert Doug Lindahl, Dr. Pratt found claimant unable to perform 6 of the 26 tasks for a 23 percent task loss. Claimant was able to return to work in the open labor market within the restrictions provided.

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[4] The first mention in the records of a lumbar problem was about nine months after the June 17, 2004, accident.

[5] Pratt Depo. at 13-14.

[6] Ibid. at 21.

PRINCIPLES OF LAW AND ANALYSIS

In workers compensation litigation, it is the claimant's burden to prove his or her entitlement to benefits by a preponderance of the credible evidence.[7]

The burden of proof means the burden of a party to persuade the trier of fact by a preponderance of the credible evidence that such party's position on an issue is more probably true than not true on the basis of the whole record.[8]

> If in any employment to which the workers compensation act applies, personal injury by accident arising out of and in the course of employment is caused to an employee, the employer shall be liable to pay compensation to the employee in accordance with the provisions of the workers compensation act.[9]

It is undisputed that claimant experienced several incidents while working for respondent. Clamant last worked for respondent on August 4, 2004, when she was let go due to violations of respondent's attendance policy. Since that time, claimant has been examined and/or treated by a multitude of health care providers for an almost endless number of complaints. However, claimant's complaints were varied and inconsistent. When examined by Dr. Fluter on October 13, 2005, claimant's Tinel's sign was absent bilaterally. On March 17, 2006, while being examined by Dr. Estivo, claimant's Tinel's sign was positive bilaterally at the wrists but negative at the elbows. EMG studies at that time were normal. On September 10, 2009, while being examined by Dr. Fluter, claimant displayed positive Tinel's at the elbows but had normal responses at the wrists. MRIs of the shoulders in 2004 were normal as were x-rays of claimant's shoulders, wrists, hips and lumbar spine in 2006. EMG studies of claimant's upper extremities on April 3, 2006, were normal.

Even though claimant last worked in 2004 when she was with respondent, her physical condition has deteriorated markedly. An MRI of the right shoulder on March 22, 2006, indicated inflammation to the supraspinatus portion of the rotator cuff as well as some thinning of the rotator cuff with a possible partial tear and some slight impingement. Degenerative changes to the AC joint were also indicated. Claimant underwent right shoulder arthroscopic surgery on January 30, 2009. Claimant's low back complaints did not surface until 2005, with claimant undergoing an L5-S1 anterior lumbar fusion in May 2008.

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[7] K.S.A. 44-501 and K.S.A. 44-508(g).

[8] *In re Estate of Robinson*, 236 Kan. 431, 690 P.2d 1383 (1984).

[9] K.S.A. 44-501(a).

The ALJ found that claimant failed to prove permanent impairment from these above described work incidents. The Board agrees. Claimant's complaints have been inconsistent and, at times, even contrary. Negative tests contemporaneous with the alleged accidents somehow became positive years later. Additionally, psychological overlay was reported by more than one health care provider. Claimant has failed in her burden of proving that she suffered permanent impairment from the described accidents. The denial of benefits for a permanent impairment by the ALJ is affirmed.

K.S.A. 2003 Supp. 44-510h states:

> (a) It shall be the duty of the employer to provide the services of a health care provider, and such medical, surgical and hospital treatment, including nursing, medicines, medical and surgical supplies, ambulance, crutches, apparatus and transportation to and from the home of the injured employee to a place outside the community in which such employee resides, and within such community if the director, in the director's discretion, so orders, including transportation expenses computed in accordance with subsection (a) of K.S.A. 44-515 and amendments thereto, as may be reasonably necessary to cure and relieve the employee from the effects of the injury.
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> (b) (1) If the director finds, upon application of an injured employee, that the services of the health care provider furnished as provided in subsection (a) and rendered on behalf of the injured employee are not satisfactory, the director may authorize the appointment of some other health care provider. In any such case, the employer shall submit the names of three health care providers who, if possible given the availability of local health care providers, are not associated in practice together. The injured employee may select one from the list who shall be the authorized treating health care provider. If the injured employee is unable to obtain satisfactory services from any of the health care providers submitted by the employer under this paragraph, either party or both parties may request the director to select a treating health care provider.
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> (2) Without application or approval, an employee may consult a health care provider of the employee's choice for the purpose of examination, diagnosis or treatment, but the employer shall only be liable for the fees and charges of such health care provider up to a total amount of $500. The amount allowed for such examination, diagnosis or treatment shall not be used to obtain a functional impairment rating. Any medical opinion obtained in violation of this prohibition shall not be admissible in any claim proceedings under the workers compensation act.
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> (c) An injured employee whose injury or disability has been established under the workers compensation act may rely, if done in good faith, solely or partially on treatment by prayer or spiritual means in accordance with the tenets of practice of a church or religious denomination without suffering a loss of benefits subject to the following conditions:
>
> (1) The employer or the employer's insurance carrier agrees thereto in writing either before or after the injury;

> (2) the employee submits to all physical examinations required by the workers compensation act;
>
> (3) the cost of such treatment shall be paid by the employee unless the employer or insurance carrier agrees to make such payment;
>
> (4) the injured employee shall be entitled only to benefits that would reasonably have been expected had such employee undergone medical or surgical treatment; and
>
> (5) the employer or insurance carrier that made an agreement under paragraph (1) or (3) of this subsection may withdraw from the agreement on 10 days' written notice.
>
> (d) In any employment to which the workers compensation act applies, the employer shall be liable to each employee who is employed as a duly authorized law enforcement officer, firefighter, driver of an ambulance as defined in subsection (b) of K.S.A. 65-6112, and amendments thereto, an ambulance attendant as defined in subsection (d) of K.S.A. 65-6112, and amendments thereto, or a member of a regional emergency medical response team as provided in K.S.A. 48-928, and amendments thereto, including any person who is serving on a volunteer basis in such capacity, for all reasonable and necessary preventive medical care and treatment for hepatitis to which such employee is exposed under circumstances arising out of and in the course of employment.[10]

However, it is found that the incidents described by claimant did occur. As such, claimant would be entitled to medical treatment sufficient to cure and relieve her of the effects of the work-related injuries. Therefore, the Award is modified to award claimant authorized medical care under K.S.A. 2003 Supp. 44-510h. Any disputes arising, regarding the medical treatment provided contemporaneous with the described accidents and what, if any, medical treatment respondent and its insurance carrier shall be responsible for, shall be presented to the ALJ for a determination.

CONCLUSIONS

Having reviewed the entire evidentiary file contained herein, the Board finds the Award of the ALJ should be modified to award claimant medical treatment pursuant to K.S.A. 2003 Supp. 44-510h, but affirmed with regard to the denial of any temporary or permanent disability.

The Award sets out findings of fact and conclusions of law in some detail and it is not necessary to repeat those herein. The Board adopts those findings and conclusions as its own.

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[10] K.S.A. 2003 Supp. 44-510h.

AWARD

WHEREFORE, it is the finding, decision, and order of the Appeals Board that the Award of Administrative Law Judge Rebecca A. Sanders dated October 29, 2010, should be, and is hereby, modified to award medical treatment under K.S.A. 2003 Supp. 44-510h sufficient to cure and relieve claimant of the effects of her work-related accidents, but affirmed with regard to the denial of temporary or permanent disability.

IT IS SO ORDERED.

Dated this ____ day of April, 2011.

BOARD MEMBER

BOARD MEMBER

BOARD MEMBER

c: Joseph Seiwert, Attorney for Claimant
Joseph R. Ebbert, Attorney for Respondent and its Insurance Carrier
Rebecca A. Sanders, Administrative Law Judge